OPERATIONAL PROTOCOL

A. Organization and Structural Administration

The Illinois Department of Public Aid (IDPA) is the single state Medicaid agency that administers the Medicaid program, and will be responsible for the implementation and operation of the SeniorCare program. SeniorCare will provide a comprehensive pharmacy benefit to seniors 65 and older whose income is at or below 200 percent of the federal poverty level (FPL) through a Section 1115 Research and Demonstration. The prescription drug benefit will be similar to the drug benefit provided under the State's current Medicaid State Plan, which covers all products that are required under the Omnibus Budget Reconciliation Act of 1990. This comprehensive pharmaceutical benefit package covers all disease states.

The Division of Medical Programs (Division) administers IDPA's Medicaid and CHIP programs. The following bureaus within the Division will perform the identified functions in SeniorCare:

Bureau of Technical Support: The Bureau of Technical Support (BTS) serves as a liaison between program areas of the Division and information systems staff of IDPA, as well as the Department of Human Services (DHS). Within this responsibility lies the development, implementation and operation of the technical aspects of Medical Programs. As an extension of this responsibility, the Bureau also serves as IDPA's link to other state agencies, organizations outside government, as well as federal agencies in the development and implementation of technical information, data exchanges and new technologies involving the Medicaid Management Information System (MMIS). The Bureau administers the Recipient Eligibility Verification (REV) system that allows providers to electronically verify participants' eligibility, check claims status, submit claims and submit information on long-term care residents. BTS is responsible for coordinating the data processing and transmission of electronic eligibility and claims files. The bureau's specific responsibilities related to SeniorCare include linking to the Department of Revenue (IDR) to exchange eligibility files and to the Pharmacy Benefit Manager (PBM) under contract for SeniorCare in order to exchange claims files and IDPA's drug formulary.

The following provides BTS's demonstration and implementation tasks timeline:

Activity	Date	Responsibility
Drug File to ESI	April 15, 2002	IDPA
Provider Notice Mailed	April 15, 2002	IDPA & Express Scripts
IDPA Internal Claim Processing Test	April 20, 2002	IDPA
Emergency Rules Passed	May 1, 2002	IDPA
SeniorCare Legislation Passed by General Assembly	May 1, 2002	IDPA & IDR
Eligibility Information Exchange between IDR and IDPA Test	May 1, 2002	IDPA & IDR
ESI SeniorCare Internal Claim Processing Tests	May 1, 2002	Express Scripts

SeniorCare ID Card Design Finalized	May 1, 2002	IDPA , IDR & Express Scripts
SeniorCare Legislation Signed by Governor	May 2, 2002	IDPA & IDR
Installation of Direct Telecommunication Line from IDPA to Express Scripts	May 15, 2002	CMS & IDPA
Direct line from IDPA to Express Scripts Configuration & System Test	May 16, 2002	IDPA & Express Scripts
Medicaid Client Eligibility File to IDR	May 18, 2002	IDPA & IDR
Direct line from IDPA to Express Scripts Claim File Exchange Test	May 20, 2002	IDPA & Express Scripts
Client Eligibility Cards mailed	May 21, 2002	IDR
First Weekly SeniorCare Client Eligibility File from IDR to IDPA	May 25, 2002	IDPA & IDR
Program Implementation	June 1, 2002	IDPA, IDR & Express Scripts
Second Weekly SeniorCare Client Eligibility File from IDR to IDPA	June 2, 2002	IDPA & IDR
First SeniorCare Claim File from ESI to IDPA	June 8, 2002	IDPA & Express Scripts
SeniorCare Claim file from IDPA to IDR	June 9, 2002	IDPA
Express Scripts Paid for First Weeks Claims	June 24, 2002	IDPA

Bureau of Comprehensive Health Services: : The Bureau of Comprehensive Health Services (BCHS) is responsible for prior authorization requests for certain medications (discussed further below) and processes requests for early refill overrides using the services of registered nurses, physicians and pharmacists in performing these activities. Staff monitor drug usage patterns of patients and prescribing patterns of practitioners. BCHS staff also oversees the preparation of invoices for billing pharmaceutical companies for federally mandated rebates. For SeniorCare, many of these functions will be performed by the PBM. The Bureau will be responsible for ensuring the PBM's compliance with pharmacy policy and providing the PBM with the following:

- IDPA's drug formulary
- list of drugs needing prior authorization
- prior authorization criteria
- other aspects of pharmacy policy

As a cost containment measure, the Department requires prior approval before certain drugs are dispensed to recipients. Examples of criteria for approval are that there be a certain diagnoses, that an alternative therapy using a different class of drug be tried first, or that a less expensive drug in the same class on the preferred drug list be tried first. The Department has an internal work-group of consulting pharmacists and physicians with expertise in pharmacology who advise the Department on which drugs should require prior approval and what the criteria for approval should be. For purposes of developing the preferred drug list, the Department contracts with a firm with extensive expertise and medical and pharmacoecomonic resources to make initial recommendations to the Department. Before requiring prior approval for any drug, the Department consults with the Drugs and Therapeutics Committee of the Illinois State Medical Society. Pharmacists and prescribing providers are sent notices when the Department puts a drug on prior approval.

Through the Department's point-of-sale system, a dispensing pharmacy is immediately notified that a prescription requires prior approval. The Department has a toll-free number pharmacists and physicians can call to obtain prior approval. The Department has pharmacists and physicians under contract who review prior approval requests. Routine prior authorizations are turned around within approximately 2 hours. Special handling prior authorizations (ones where the Department is monitoring for step therapy, or applying other special criteria) are resolved in approximately six to seven hours. Prior authorization requests received by the Department during the night are usually resolved by 10:00AM the next morning. In addition, Department rules (89 Ill.Adm Code 140.442 (d)) state "In an emergency situation, the Department shall provide for the dispensing of at least a 72-hour supply of a covered prescription drug." In SeniorCare, ESI will process prior approval requests. ESI's procedures are discussed in Section F.

Bureau of Rate Development and Analysis: The Bureau of Rate Development and Analysis (BRDA) develops new rate structures for institutional and non-institutional providers in order to most effectively allocate newly appropriated revenues and provide increased access to healthcare for all Medicaid clients. Additionally, BRDA develops accurate budget estimates for the appropriations administered by the Division of Medical Programs and analyzes historical data, policy changes, demographic movement and various other influences to estimate future liability for all medical distributive lines. The Bureau performs fiscal analysis for decision memos, policy initiatives and changes, program changes, and State/Federal legislation; tracks Medicaid spending and utilization trends and Medicaid eligibles and member months by eligibility groups, i.e. AABD, TANF, DCFS, KidCare, etc. Significant time and effort is spent performing utilization/Chronic Illness studies e.g. HIV/AIDS, Asthma, Diabetes, etc., ad hoc analysis, reporting, and data extraction for the Department, Division, Bureau of the Budget, other state agencies, and external organizations, including Freedom of Information Act requests and performing detailed level expenditure analysis for use in rate setting. The Bureau monitors the NOMAD claim databases to ensure accuracy and efficiency and is steering the development of the data warehouse.

Bureau of Medical Administrative Support: Bureau of Medical Administrative Support: The Bureau of Medical Administrative Support (BMAS) includes the Provider Participation Unit (PPU) and the Management Support Unit (MSU). The PPR enrolls and maintains the Provider Database for over 128,000 providers participating in the Illinois Medical Assistance Programs. This unit will coordinate with the PBM to ensure that all providers in the PBM network are enrolled with IDPA as Medicaid providers. The MSU processes C-13 payment vouchers via Public Aid Accounting System (PAAS). After invoices have been received from the PBM and approved by the Bureau of Contract Management, the invoices are submitted to MSU who verifies the corresponding contract information and enters the invoice into PAAS. The entering of the invoice into PAAS documents the expenditure of the funds from the contract with the PBM. The invoice in PAAS receives Agency approval and is then submitted to the Comptroller for payment.

Bureau of Program and Reimbursement Analysis: The Bureau of Program and Reimbursement Analysis (BPRA) provides analytic and technical support services for all the Medicaid programs administered by IDPA as well as other state agencies. BPRA coordinates the development of policy necessary for the operation of the health benefit programs administered by the Department. BPRA serves as the lead bureau for policy issues related to provider reimbursement and eligibility, and

coordinates the development of administrative rules and policy related materials necessary to secure federal matching funds for those programs. BPRA coordinates the review of legislation affecting the Medical Assistance Programs, drafts and/or coordinates position papers and prepares implementation plans when necessary. BPRA monitors the financial aspects of those portions of the Medicaid program that are administered by nearly 800 other government entities—other state agencies, counties, cities and local education agencies—and monitors the rates, payment policies, and claiming processes used by those other agencies to pay and claim for Medicaid services and administrative activities.

Bureau of Contract Management: The Bureau of Contract Management (BCM) is responsible for the oversight and monitoring of most of the Division of Medical Programs' major contracts including the dental administrator contract, non-emergency transportation prior-approval program contract and peer review organization contract. In addition to the above contracts, BCM administers Illinois' voluntary managed care program and monitors contracts with participating managed care organizations.

BCM also operates the Health Benefits Hotline, a toll-free hotline utilized by clients and providers with questions regarding the Medicaid and KidCare programs, including eligibility verification.

BCM is responsible for SeniorCare outreach and education.

Illinois Department of Revenue: The Illinois Department of Revenue (IDR) operates Illinois' current state funded pharmaceutical assistance program for seniors, the Circuit Breaker/Pharmaceutical Assistance Program. The Pharmaceutical Assistance Program is housed in the Taxpayer Services Administration. Pursuant to an interagency agreement between IDR and IDPA employees in this section will accept and process applications for both the Circuit Breaker/Pharmaceutical Assistance Program and SeniorCare. They will make eligibility determinations and place applicants in the appropriate program. IDR will then create an electronic eligibility file to be transmitted to the PBM and to IDPA. IDR will also be responsible for the creation and issuance of member ID cards for SeniorCare. Final language for the Interagency Agreement (copy attached) has been agreed to by staff from both agencies and the signature process has been started. The agreement should be signed by May 20, 2002.

B. **Reporting Items**

Monthly Progress Calls: Before and for six months after implementation IDPA and CMS will hold monthly calls to discuss demonstration progress. After six months of operation, IDPA and CMS will determine the appropriate frequency of progress calls.

Quarterly & Annual Progress Reports: IDPA will submit quarterly progress reports that are due 60 days after the end of each quarter. The fourth quarterly report of every calendar year will include an overview of the past year as well as the last quarter, and will serve as the annual progress report. IDPA's report will address, at a minimum, the following:

- a discussion of events occurring during the quarter (including enrollment numbers, lessons learned, and a summary of expenditures)
- notable accomplishments

- an assessment of IDPA's maintenance of effort
- problems/issues that were identified and how they were solved

Final Report: At the end of the demonstration, IDPA will submit a final draft report to CMS for comments. The CMS' comments shall be taken into consideration by IDPA for incorporation into the final report. IDPA will submit the final report, with CMS' comments, no later than 180 days after the termination of the project.

Financial Reporting

The budget neutrality agreement under this demonstration requires the state to capture and report financial expenditures in accordance with the special terms and conditions for 1)individuals enrolled in the demonstration (demonstration enrollee) and 2)the non-demonstration aged. This section of the operational protocol describes the policies and procedures that are necessary to implement the financial reporting requirements in Attachment A of the Special Terms and Conditions.

Illinois will modify its Medical Management Information System (MMIS) in order to facilitate expanded expenditure and budget reporting to CMS for the following reporting objectives:

- Reporting/claiming Federal Financial Participation (FFP);
- Tracking against the 1-year expenditure targets and the 5-year FFP cap;
- Estimating/Budgeting;
- Distinguishing expenditures separately for the individuals enrolled in the demonstration and for the non-demonstration aged populations; and
- Distinguishing expenditures by date of service to report expenditures in the correct demonstration year.

The Medicaid and State Children's Health Insurance Program Budget and Expenditure System - (MBES/CBES)

All claims related to the budget neutrality agreement will be reported on the State's quarterly CMS-64 expenditure report via the MBES/CBES. After entering this system, the State will access the appropriate forms by selecting the CMS-64 button on the left side of the screen. The State will click-on add/modify, then select the appropriate waiver reporting form from the drop down menu provided at the bottom of the screen. This drop down menu will provide access to the reporting Forms CMS--64.9 WAIVER, CMS-64.9P WAIVER, CMS-64.10 WAIVER, and CMS-64.10P WAIVER. These forms add directly into the CMS-64 Summary Sheet. This insures that the State will receive Federal match for all title XIX waiver expenditures. Once the appropriate form has been selected and entered, the State will either click-on the "add" bar to add a new waiver sheet or the "modify" bar to modify a waiver sheet that has already been entered into the system. Once this selection has been made, the next screen will provide a chart of all waivers for Illinois. The chart provides information

for each waiver by Waiver Type, Waiver Number, and Waiver Name. The waiver type column includes 1115, 1915(b), and 1915(c) waivers. The next column provides the waiver number. For 1115 waiver numbers, a block is included that needs to be completed with the correct demonstration year (i.e., -01, -02, -03, etc.). The demonstration year entered into the system will be the demonstration year in which services were rendered or for which capitation payments were made. Lastly, the list is grouped by waiver name. The waiver name consists of those eligibility groups or reporting categories identified in the Special Terms and Conditions and/or Operational Protocol. The eligibility groups for this demonstration will be identified as 1) ***demonstration enrollee*** for individuals enrolled in the demonstration or 2) ***non-demonstration aged***. A separate CMS-64.9 WAIVER and/or CMS-64.9P WAIVER will be completed for each eligibility group covered under the budget neutrality agreement.

All capitation payments will be reported on line 18.A. of the Forms CMS-64.9 WAIVER and CMS-64.9P WAIVER. All fee-for-service (FFS) expenditures will be reported on the appropriate service line on the Forms CMS-64.9 WAIVER and CMS-64.9P WAIVER.

In order to achieve the necessary expenditure tracking by demonstration year, the last two digits of the "WAIVER NUMBER" data entry field will be extremely critical. The demonstration year is included as a part of the "WAIVER NUMBER" and is identified as a part of the extension. For example, Illinois waiver number is 11W00140/ with the extension of 5-xx. The 5 represents the Chicago Region and the xx represents the demonstration year.

EX: Assume the implementation date was April 1, 1999. Expenditures reported for the quarter ended March 31, 20XX will be broken out by date of service and assigned to the correct demonstration year (/5-0X (current year) or /5-0X-1, etc.) on the current quarter expenditure report (03/31/XX). Capitation payments made in that same quarter (March 31, 20XX) for services covered in April 20XX will be claimed on the current quarter expenditure report (March 31, 20XX), but will be assigned to the next demonstration year (/2-0X+1).

Tracking of expenditures against the annual expenditure targets and the 5-year cap will begin June 1, 2002. The "first demonstration year" for budget neutrality purposes will be defined as extending from June 1, 2002 through May 31, 2003. For expenditures being claimed for dates of service beginning June 1 of each succeeding demonstration year, replace the last two digits with -02 through -05, respectively. In this way, Illinois and CMS will be able to track the 1115 demonstration expenditures to the correct year of the expenditure target/cap. The expenditures for each demonstration year will be automatically accumulated on the CMS-64 Waiver Expenditure Report - Schedule C. The State will access this report on a quarterly basis to monitor its expenditures under the budget neutrality cap.

All offsetting adjustments attributable to the budget neutrality agreement that would normally be reported on lines 9 or 10.C. of any CMS-64 will be reported on line l0.B. The MBES/CBES system does not allow for these adjustments to affect waiver expenditures. Therefore, in order for these adjustments to be credited to the State's 1115 waiver expenditures, these offsets must be reported on line 10.B. and identified with the correct waiver information. This will allow these claims to be included in the CMS-64 Waiver Reports (Schedules A, B, and C) that the State will access and use

as a tracking mechanism. Waiver Schedule A will provide waiver expenditures claimed for the current quarter. Waiver Schedule B will provide a cumulative total for previous waiver expenditures as reported, current quarter expenditures, and the total expenditures to date. Waiver Schedule C provides a breakout of waiver expenditures to date by WAIVER NAME, by demonstration year, and totals for both Total Computable (TC) and Federal Share (FS). For any other cost settlements (i.e., those not attributable to the budget neutrality agreement), the adjustments will be reported on lines 9 and 10.C., as instructed in the State Medicaid Manual.

Quarterly CMS-64 Reports: IDPA will submit quarterly reports that are due 30 days after the end of each calendar quarter. The Bureau of Federal Finance (BFF) is in the early stages of requesting special MMIS reports that will accommodate federal reporting requirements. BFF has been in contact with the CMMS Illinois Accountant-in-Charge, Dave Brunelle, and has expressed concerns with the cost neutrality reporting, as described in the special terms and conditions. CMMS, in the special terms and conditions, has requested that all expenditures of persons 65 and older be reported on the CMS-64.9 WAIVER and 64.9P WAIVER. This will result in the reduction of 1915C waiver expenditures and disproportionate share payments by the amount of claims paid for any persons 65 and older. As the CMS-64 is a CMMS report, we are awaiting direction. Until CMMS can give further guidance on how the waiver and cost neutrality are to be reported on the CMS-64, the discussion of details on how the IDPA will report these costs on the CMS-64 is limited to general assertions as follows.

Medical Assistance

- Reporting of this waiver will be identified by the age of the recipient at the date of service. If the recipient is 65 years of age or older, their costs will be captured in claiming reports. (Take existing claiming reports and capture this data via age of recipient for dates of service from approval date of waiver forward – Report A) The results will go on the CMS 64.9. *Per the special terms and conditions, "For each demonstration year a Form CMS-64.9 WAIVER and/or 64.9P Waiver will be submitted reporting expenditures subject to the budget neutrality cap. On the form, report the expenditures for individuals enrolled in the demonstration. The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in 2.c.) 2c. For the purpose of this section, the tem 'expenditures subject to the budget neutrality cap' will include all Medicaid expenditures on behalf of individuals who are enrolled in the demonstration and all expenditures made for service costs for the non-demonstration aged Medicaid eligibility group. All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and will be reported on Form CMS 64.9 WAIVER and /or 64.9P WAIVER."*
- The remaining costs of recipients not in SeniorCare or 65 years of age or older with dates of services previous to the waiver approval date will be captured in claiming reports. (Take existing claiming reports and capture this data – Report B The results will populate the remaining CMS-64)
- The total of Reports A, and B will equal total spending for the quarter and balance back to MMIS source reports reflecting total spending in MMIS. This will prove that claims are not duplicated in the CMS-64.

Medical Administration

- Administrative costs associated with this waiver will be tracked and reported quarterly. BFF will amend the Public Assistance Cost Allocation Plan. Costs will be captured through the Supportive Medical Allocation. This allocation spreads medical related administrative costs to the benefiting federal programs by profiling the number of claims paid by federal eligibility status of the recipient receiving the service. This particular allocation will be amended to add a SeniorCare bucket to the Supportive Medical Allocation. SeniorCare claims are identified via a unique indicator that appears on each claim.

Quarterly CMS-37 Reports: IDPA will submit quarterly estimates that are due 45 days after the end of each calendar quarter.

Co-payment Amounts collected from enrollees: Provider collected co-payment amounts will not be included in the CMS-64. The IDPA pays the claim amount net of any provider collected co-payments. As such the CMS-64 captures expenditure data net of provider collected co-payments.

C. **Cost-Sharing**

Participants will share the costs of SeniorCare pharmacy benefits. There is no enrollment fee but a participant may be required to pay a co-payment, collected and retained by the pharmacy, in order to have a prescription filled. The cost-sharing is detailed in informational brochures used for outreach and promotion. In addition, when an enrollee receives his or her SeniorCare card, they receive a form that details the cost-sharing requirements for use of the card. The following describes the cost sharing features in more detail:

- Participants with a household income below the FPL will not be required to pay a co-payment for prescriptions until the accumulated annual expenditures incurred by the participant reach $1750, then the participant will be required to pay a 20% co-payment. On July 1, of each year, all SeniorCare participants will begin with a new $1750 threshold, even if they were initially enrolled at any time after July 1 of the previous year (i.e. they had been enrolled for less than 12 months).
- Participants with a household income equal to or greater than the FPL will be required to pay a $1 co-payment for generic and $4 co-payment for brand name prescription. Once total annual expenditures incurred by the participant reach $1750, a participant will be required to pay the $1 co-payment for generic or $4 co-payment for brand name prescriptions plus 20% of the remaining costs.
- If a generic drug is available and the participant wants a brand name drug, they will pay the applicable cost sharing for the generic plus the difference between the generic price and the brand name price, unless the drug is a federally defined narrow therapeutic index drug and substitution is not permitted because the physician has indicated "brand medically necessary".

Future Adjustments to Cost Sharing: If modifications were warranted to control program costs, the upper limit for the initial per prescription co-payment would be $10.00. If modified, the lower limit for the threshold at which the percentage co-payment becomes applicable would be $1,000.00.

Within the per prescription co-payment limit specified above, IDPA may institute a co-payment structure to create an incentive for providers to prescribe drugs that are medically and economically appropriate. These changes will be submitted, reviewed, and approved by CMS prior to implementing the changes.

D. **Cost Sharing Protections**

The only cost sharing for enrollees will be the co-payments due at the time the prescription is filled. Co-payments must be paid in order to have the prescription dispensed. The only consequence of failure to make co-payments is that the prescription may not dispensed. Therefore, there will be no disenrollments or other adverse actions taken as a result of failure to meet cost-sharing obligations and no specific protections are needed.

E. **Coordination with Private Health Insurance Coverage**

Crowd-Out from Expanded Pharmacy Services: The Current Population Survey indicates that approximately 20 percent of the eligible population for this program may have benefits available to them from employer-sponsored private insurance. IDPA does not believe that implementation of this program will have a significant impact (crowd-out) on the number of individuals that maintain such insurance. Crowd-out concerns surfaced in the past as a result of various Medicaid expansions and the implementation of the State Children's Health Insurance Program (SCHIP). However, crowd-out with SCHIP appears to have been minimal. The lack of crowd-out has been so minimal that CMS substantially eased requirements for certain anti-crowd-out strategies in its final SCHIP regulations over what had been required by the proposed regulations. With respect to SeniorCare, crowd-out is less of a potential problem simply because there is less to crowd-out. The rebate program, as described below, will be implemented to prevent crowd-out from occurring. Prescription drug coverage is by far the single most significant gap in coverage for seniors.

The SeniorCare Rebate Program: Illinois' approach to crowd-out in SCHIP has been to provide an incentive for families to maintain their children's health insurance through a rebate program as an alternative to direct benefits. Evidence suggests that the rebate program was a successful strategy. SeniorCare has been designed to provide similar financial incentives for seniors to maintain pharmacy benefits they already have. The successful Illinois SCHIP strategy is expected to be equally successful in SeniorCare.

All seniors enrolled in SeniorCare will be mailed a form that includes a SeniorCare card. The bottom half of the form explains, as an alternative to direct benefits available by using the SeniorCare card at pharmacies, they may opt to receive a $25.00 monthly check to help with the cost of out-of-pocket cost sharing for their existing prescription drug coverage. The form will explain that if they choose this option, they must list the details of their current insurance that provides a prescription drug benefit and return the bottom half of the form to IDR. The form also informs the senior that the SeniorCare card they received will be cancelled once they are enrolled in the rebate program. IDR will then forward the form to IDPA's Bureau of Collections, which will verify coverage from a randomly selected sample of the forms. An account will be set up for each senior requesting a rebate and checks will be mailed monthly through IDPA's PAAS system. Although the

Department hopes that seniors with private coverage choose the rebate program, an individual with private prescription drug coverage could use the SeniorCare card to supplement private coverage that did not meet all of the senior's prescription drug needs.

IDPA subcontracted with an outside actuarial consulting firm to assist in the creation of the $25.00 rebate amount. An assumption used was that an industry standard for employer based insurance was coverage of 80% of costs. Using the Medicaid aged population as a proxy, the Department determined average monthly cost based on utilization shown by claims data. The $25.00 amount represents 20% of the average monthly cost.

F. **Pharmacy Services, Providers, and Benefit Management**

The pharmacy benefit for SeniorCare provides access to the products from rebating manufacturers as provided under the Omnibus Budget Reconciliation Act of 1990, and includes treatments for all disease states. This is the same benefit provided to recipients in this age group within the Medical Assistance program as outlined in the Medicaid State Plan. This includes the over-the-counter drugs available to regular Medicaid beneficiaries with a doctor's order. Some drugs may require prior approval (see Section A above and subsection on Prior Authorization below in this section). Prescriptions are limited to a 30-day supply at each dispensing with a refill-to-soon edit.

Method of services provision: This is a fee-for-service program. SeniorCare enrollees will receive a SeniorCare card which will be accepted at any pharmacy in Illinois that is enrolled with the Medical Assistance program and enrolled with the programs' pharmacy benefit manager (PBM). Prescriptions from any physician, dentist, podiatrist or other providers licensed to prescribe medications will be accepted. The providers treating the enrollees and writing the prescriptions do not have to be enrolled as Medicaid providers and do not need any affiliation agreement with the PBM.

Detailed description of the role of a pharmacy benefit manager: Express Scripts (ESI) is the PBM working with Illinois Department of Revenue (IDOR) to operate the existing Circuit Breaker/Pharmaceutical Assistance program. IDPA is amending this contract to include expanded coverage to persons at or below 200% FPL. ESI will manage the provider network and IDPA will insure that all participating pharmacies are enrolled Medicaid Providers. ESI will negotiate reimbursement rates with network providers using market-based practices as are regularly negotiated for private third party plans. They will also handle claims processing including performing concurrent and retrospective drug use review editing, generate payment for covered services, provide pharmacy help-desk functions and provide IDPA with electronic files of paid claims data which will pass through the MMIS systems.

Which practitioners will be providing care: SeniorCare beneficiaries will be able to continue seeing their current physician. No restrictions are imposed limiting access to either primary or specialty physicians. Medical care to enrollees of SeniorCare will be provided by any physician, dentist, podiatrist or other providers licensed to practice medicine.

Participating pharmacies in this demonstration must be enrolled as a Medicaid provider and meet the same requirements. They must hold a current Drug Enforcement Administration (DEA) registration

issued by the United States Drug Enforcement Administration and a current controlled substances license issued by the Illinois Department Professional Regulation. The pharmacy must also be enrolled with ESI. The ESI network which will be used in Senior Care is their PERxSelect network. In this network each pharmacy enters into a contract with ESI for a negotiated rate. The ESI PERxSelect network currently has 2268 Illinois providers. The Medicaid Program currently has 2284 Illinois providers. All Medicaid pharmacies not enrolled with ESI will received a notice the week of May 5 informing them of the requirements for serving SeniorCare and procedures for enrolling with ESI.

How the state will ensure access to an adequate number of pharmacies: The contract with ESI requires they insure their network is adequate to serve the program. All providers of the SeniorCare pharmacy network must be currently enrolled with IDPA. A match of their network against IDPA's MMIS pharmacy enrollment files for other Medicaid beneficiaries has determined that only a handful of those in IDPA's network were not in the network which will serve SeniorCare. No access to care issues exist regarding the SeniorCare network distribution of members. The SeniorCare network will accept "any willing provider" who meets IDPA's enrollment criteria. ESI will provide regular reports to IDPA regarding network enrollment. Reports will include information regarding the geographic distribution of enrolled pharmacies. ESI will be responsible for addressing access problems if this monitoring process detects a problem in the future. IDPA is confident that access to pharmacy services for participants in the SeniorCare program will be consistent with access for the general population in Illinois. ESI will receive a file of persons eligible for SeniorCare form IDR; mange the pharmacy provider network; negotiate rates, perform concurrent and retrospective Drug Utilization Review, perform prior authorization review, process claims, generate payment for approved claims, staff 24 hour help lines for provider pharmacies and SeniorCare enrollees; provide IDPA with electronic files of paid claims as well as regular electronic and hard copy reports

IDPA will monitor ESI through data analysis, utilization review and customer satisfaction. This is discussed with more detail in Section J.

The methodology for determining reimbursement to providers: The contract with ESI was obtained through a request for proposals. It will be amended to add the SeniorCare population to their existing duties. The acquisition cost reimbursement rate and dispensing fee that IDPA pays to ESI are market-based rates. ESI in turn negotiates market based contract rates with pharmacies in its network. It will be ESI's responsibility to insure an adequate network is maintained at the rate it has contracted with IDPA.

The contracts which ESI has with each pharmacy within their network specifies their network reimbursement rate. It is that network rate which will be used to reimburse SeniorCare services. The ESI reimbursement to pharmacies will be the lessor of the pharmacy's usual and customary charge or the network rate. Reimbursement to ESI from the Department will be AWP –14% for brand name drugs and a weighted average of AWP – 50% for generic drugs (based on a Maximum Allowable Cost (MAC) list), plus a dispensing fee of $2.55. This compares to the current Medicaid rates of AWP –11% for brand name drugs, AWP –20% for generic drugs and a dispensing fee of $4.00 for brands and $5.10 for generics.

How any accompanying pharmacy service, such as a prior authorization system, will be utilized under the demonstration: The Department will determine which drugs require prior approval in SeniorCare. ESI will process prior approval requests. Through the point-of-sale claims processing system, a dispensing pharmacist is immediately notified that a prescription requires prior approval. In some instances, the system will search the paid claims data base for previous prescriptions to the recipient to determine if requirements for alternative therapies have been met, and the prescription will be systematically approved without any further action by the pharmacy or recipient. In other instances, the pharmacist or the prescribing provider will call an ESI toll-free number to obtain prior approval. This number is staffed 24 hours per day, seven days per week. Most prior approval requests can be solved during the phone call, otherwise, they are resolved within24 hours. In emergency situations, the Department will pay for the dispensing of a 72-hour supply of a covered drug until the prior authorization is resolved.

Describe the prospective and retrospective DUR features that will be applied:
The claims processing software features used by ESI for SeniorCare will include both prospective (concurrent) and retrospective Drug Utilization Review (DUR) components. The concurrent edits for SeniorCare are primarily patient safety oriented and examine the current claim against patient specific history as well as medication safety. System alerts are returned to the dispensing pharmacy when problems are detected. Both informational and hard edits may be returned depending upon the nature of the problem detected. Hard edits are all overrideable if an override is warranted.

Examples of concurrent DUR edits that will be in place June 1, include early refill, drug-age precautions, drug-drug interaction, high dosage precautions, excessive quantities, and therapeutic duplication detection. The system also has step-therapy type features that insure preferred drugs are tried before coverage is available for non-preferred or prior authorized medications. Retrospective DUR analysis and interventions are performed based upon retrospective analysis of claim data and is focused toward optimizing medication therapy. The primary focus currently includes a program regarding the review and simplification of complex drug therapies. The program goal is to help seniors manage complex medication regimens by encouraging physicians to coordinate care and simplify therapy where appropriate. Another is a drug age education and drug interaction education program designed to identify patients whose medication use history suggests the potential for inappropriate therapy. Examples include serious drug-drug, drug-disease, or drug-age interactions and the program encourages appropriate review and prescribing changes with a goal of decreasing the risk of adverse drug events. These ESI educational interventions use patient specific written material to educate prescribers. These letters provide prescribers with the patient's current drug history and recommendations regarding potential inappropriate therapies, excessive duration, or compliance issues. Claim data will also be passed to MMIS and subjected to all the in-house retrospective analysis performed with other patient medications. (See hard copy attachment *Descriptions of Clinical Programs*)

G. **Related Medical Management**

All individuals enrolled in SeniorCare will be made aware of the Department's Health Benefits Hotline. One of the normal functions of the hotline is to refer Medicaid recipients to health care providers. The Hotline, staffed with 21 operators (six bilingual) is open from 8:00 a.m. to 6:00 p.m. five days a week.

Hotline operators are able to identify convenient providers by entering the recipient's zip code into the computer. The operator will then provide the names, addresses and phone numbers of three to four providers in the caller's community. Referrals can be made for both primary care and for specialists. Callers are encouraged to call back if then are not successful in getting an appointment with the providers identified so that more options can be given to them. The call back rate is about 2%. For non-Medicaid, non-Medicare eligible uninsured individuals, the hotline staff has several identified referral options—FQHCs, RHCs, County Health Departments and Access to Care (Cook County) and Access DuPage (these programs provide primary care to uninsured individuals not eligible for Medicaid). Also, the Department has a contract with Catholic Charities to provide referral services in north and northwest suburbs of Chicago and in the Rockford area. One of Catholic Charities' contract duties is to recruit doctors willing to take referrals. Although the Department does not have a data base of Medicare providers, most doctors who accept Medicaid will accept Medicare. Therefore, the Department will use its Medicaid providers for referrals for Medicare covered individuals. Through this process the Department will ensure that all SeniorCare participants have access to primary health care.

H. **Outreach/Marketing/Education**

Strategy: The outreach plan for SeniorCare is a coordinated effort of those Human Service Agencies in Illinois State Government having contact with Senior Citizens. IDPA will lead the effort. The Department of Revenue (IDR), as the agency responsible for administration of the Circuit Breaker/Pharmaceutical Assistance program will accept and process applications, and transmit to IDPA either directly or through ESI an eligibility file for persons found eligible for SeniorCare. The Department on Aging (IDOA) funds and trains statewide area offices on aging which assist senior citizens with application for various social service programs, including pharmaceutical assistance. These area offices in turn train two hundred assistance sites throughout Illinois. The Department of Insurance (IDOI) has an expansive network of approximately seven hundred volunteers throughout Illinois who are trained to assist seniors with all aspects of medical insurance. These volunteers, with the network funded through IDOA, will become the front line in SeniorCare's community based outreach. The Department of Human Services (DHS) determines eligibility for cash and medical assistance for the Aged. It will assist in identifying potentially eligible seniors already receiving some type of assistance by reviewing income information in its data base for individuals enrolled in Medicaid with a spenddown or in other programs (e.g., food stamps). DHS has been an integral part of the outreach planning team, and has participated in development of all SeniorCare promotional and educational materials. The DHS hotline and field staff will be trained at the workshops, will have SeniorCare brochures available, and will receive additional information about the program through notices and periodic updates. DHS Representatives attending the statewide workshops are expected to take their information back to their respective field offices.

A core group of key staff from these agencies began meeting in early March to learn about SeniorCare, discuss existing networks likely to disseminate information, react to promotional materials and plan for training and implementation of the program. The outreach plan has three components: electronic identification of potential eligibles; education and training of IDOA's grantees and IDOI's volunteer networks; and media.

Electronic identification:

Roll over from existing Circuit Breaker/Pharmaceutical Assistance to SeniorCare: SeniorCare targets a subset of individuals currently receiving limited pharmaceutical assistance through IDR's Circuit Breaker/Pharmaceutical Assistance programs. This program, in effect since 1985, provides assistance to seniors up to 250% of the FPL. SeniorCare targets individuals up to 200% of FPL. Computer programming has been completed to identify those seniors, already receiving assistance through Circuit Breaker/Pharmaceutical Assistance who are at or below 200% of FPL. This program, scheduled to run on or about May 21, 2002, is expected to identify approximately 130,000 individuals eligible for SeniorCare. SeniorCare cards, with June 1, 2002 effective dates, will be produced for these individuals, accompanied by a notice explaining SeniorCare, the expanded prescription coverage now available and toll free phone numbers to call with any questions

Pending: The Circuit Breaker Program includes benefits other than Pharmaceutical Assistance. The application used for Circuit Breaker/Pharmaceutical Assistance/SeniorCare requires seniors to check a box if pharmaceutical assistance is requested. Some individuals may not have requested Pharmaceutical Assistance because IDR's limited formulary was not of benefit to them. Special mailing labels are included in the application packet, which differentiate between applications for "Circuit Breaker only" from applications requesting Pharmaceutical Assistance. Applications with the mailing label for Pharmaceutical Assistance are given special priority. During the transition period from demonstration approval to implementation, seniors may not be aware of the expanded pharmacy benefits available under SeniorCare. As a part of the transition to SeniorCaare implementation, IDR will target, as a one-time effort, persons at or below 200% FPL who applied only for Circuit Breaker tax assistance for special outreach. Once the word is out about expanded coverage to most all health conditions, we expect many seniors will want to be considered for the program. Once IDR identifies persons at or below 200% FPL who qualify and applied only for Circuit Breaker assistance, IDR will send a notice that will also serve as a SeniorCare application. If interested, the senior will sign the application form and return it in a self-addressed envelope. Two notices have been developed. (see attached) ADAD-41 will be sent to seniors with income less than 100% FPL. ADAD-42 will be sent to seniors with income 100% - 200% FPL. A "mass mailing" planned for early May will target seniors currently receiving "Circuit Breaker only." Weekly mailings to new eligibles are planned until the end of December, 2002.

Seniors on QMB/Spenddown: IDPA intends to identify qualified Medicare beneficiaries (QMB) and seniors designated as having spendown obligations on the client data base for special notice about SeniorCare. Seniors with QMB are likely to be eligible for SeniorCare. IDPA currently pays the monthly Medicare premiums and any co-payments for Medicare covered services. Since most prescription drugs are not covered by Medicare, it is most likely these individuals will benefit from the expanded prescription coverage available under SeniorCare. Preprinted applications, containing information available from MMIS will be mailed to potentially eligible seniors who have QMB. A notice will accompany the applications explaining SeniorCare and encouraging that the application be completed. The notice will include toll free phone numbers for assistance.

Seniors eligible with a spenddown will also be targeted for special outreach for SeniorCare. They will be identified on the client database and sent a notice explaining the expanded coverage available under SeniorCare. These individuals may have chronic health conditions, such are renal failure, requiring extensive medical care. The hotline will be available to assist these seniors as well.

Successful implementation of these electronic notification processes will assist the State to reach the estimated 368,000 seniors potentially eligible.

Information that will be communicated to enrollees, participating providers, and State outreach/education /intake staff: There are two campaigns on education and training for SeniorCare. The campaign for enrollees will target potentially eligible senior citizens and the public and social service advocacy groups that most often come into contact with them. The education and training campaign for pharmacy providers will focus on information needed to enroll as part of the network providing prescription benefits to seniors under the program.

Education and training for seniors and their public and social service advocacy groups will focus on the following components of the programs: eligibility requirements; covered benefits, cost sharing; application process; eligibility period; accessing services and where to call with questions.

A brochure has been developed which describes the program components**.** These will be initially available in English and Spanish. The brochure is designed so those community-based sites may stamp or attach a label with information identifying their local address and phone number.

IDPA and IDR are working with ESI to educate pharmacies about SeniorCare. In order to participate, pharmacies will need to be enrolled as a medical provider with IDPA and also be enrolled with ESI. Provider relation's staff from ESI will begin personally contacting the large pharmacy chains that participate in the existing pharmaceutical assistance program the first week in April. Provider notices from ESI to their enrolled providers and from IDPA to all pharmacies enrolled in the medical assistance programs will mailed in mid April explaining the program, the expanded benefit and the procedures to enroll in both programs. Additional notices are planned as implementation nears to address anticipated questions about billing, prior approval, Medicare covered supplies, etc. Staff from ESI and IDPA is also available via toll free provider inquiry lines for additional information about SeniorCare.

Enrollees will be informed of cost sharing requirements by notices. ADAD-38 (see attached) will be mailed during the third week in May to persons who are currently enrolled in the Pharmaceutical Assistance program with income less than 200% FPL. Express Scripts and the Health Benefits hotline will be able to identify the amount of the co-pay when seniors call requesting more specific information. ADAD-39 (see attached) will be mailed to persons who have not previously been enrolled in the pharmaceutical assistance program. System limitations have prohibited us from linking a letter that personalizes an enrollee's co-pay requirement with a SeniorCare card.

Pharmacies will electronically receive information that identifies the enrollees and their co-pay amount. The electronic file will also track the amount of SeniorCare benefits paid to alert the pharmacy when the $1,750 threshold is met, which will let the pharmacy know the senior has an additional 20% co-pay per prescription.

Types of media to be used: The brochure will be the primary written document about SeniorCare, particularly during implementation. Notices are also planned, as described earlier, to reach specific groups and to describe the program to people determined eligible on or after June 1, 2002.

Consideration is being given to PSAs, inserts in utility bills, pharmacy prescription "packs", grocery bags and other similar outreach tools.

Specific geographical areas to be targeted: Outreach for SeniorCare will be statewide.

Locations where such information will be disseminated: Outreach and training will rely heavily upon existing networks within the IDOA and the IDOI. These networks consist of individuals and agencies throughout Illinois who are specially trained to inform Senior citizens about all matters pertaining to their health care. The networks are well versed in the circuit breaker/pharmaceutical assistance program operated by IDR and will advocate for potentially eligible seniors in their areas to apply for the expanded coverage available through SeniorCare. These networks of established, community-based agencies are located throughout Illinois in urban as well as rural areas. Since the local agencies are attuned to the demographic and geographic conditions in its community, outreach techniques will be tailored to urban or rural conditions. This community-based outreach model promotes effective distribution of information to seniors in all areas of Illinois.

Staff training schedules, schedules for State Forums or seminars to educate the public: Training sessions are planned for May 2002 in Springfield, Rockford, Mt. Vernon and Chicago and a videoconference is planned for June 2002 to introduce SeniorCare. The training will be conducted by representatives of IDPA, IDR, IDOA and IDOI and will cover the program basics, as well as detailed instructions on the application process. Notices about the training will be sent to all Area Offices on Aging and their affiliated community sites, all volunteers in IDOI's Senior Health Insurance Program (SHIP) network, IDR district offices and DHS local offices.

Staff answering four separate hotlines operated by IDPA, IDR, IDOA and IDOI have been trained on SeniorCare and can direct seniors to local sites for assistance, answer basic program questions and can assist by mailing applications. Person calling IDPA's Health Benefits Hotline (1-800-226-0768) can be linked with translators speaking over 150 other languages. The IDPA and IDR hotlines have separate TTY numbers to assist persons who are hearing impaired.

In addition, a SeniorCare web site is being developed which will contain all pertinent program information, as well as link to IDRs online application and IDOAs community based application assistance sites.

I. Eligibility/Enrollment

Eligibility Determination: The eligibility determination will be completed by IDR. A person can receive an application by contacting IDR or by down loading the application from IDR's web site. Persons can also contact IDOA, their local Area Agency on Aging or IDOI's Senior Health Insurance Program (SHIP) for applications. These agencies may also assist the applicant in completing the application. When IDR determines the applicant is eligible for SeniorCare, a notice and the SeniorCare Card will be sent to the applicant.

Persons who are not eligible for SeniorCare will be considered for the Pharmaceutical Assistance Program. Those who are not eligible for either will receive a notice of denial. Specific eligibility rules follow:

1. Residence	Must meet current Medicaid rules.
2. Immigration Status	Must meet current Medicaid rules.
3. Age	Must be age 65 or older.
4. Application	Application for SeniorCare will be made on existing Circuit Breaker and Pharmaceutical Assistance application. These applications can be completed in hard copy and submitted by mail. The State may develop special SeniorCare only mail-in application. For either the current or any future versions of the application, eligibility will not be determined for other Medicaid programs.
5. Processing	Application will be processed by the Illinois Department of Revenue.
6. Eligibility Period	All participants will be put on a state fiscal year eligibility period (July 1 through June 30). Therefore, persons enrolled in SeniorCare for the first time between July 1 and December 31 will receive coverage for the remainder of that fiscal year, a period of less than twelve months. Persons enrolled in SeniorCare for the first time between January 1 and June 30 will receive coverage for the remainder of that fiscal year plus all of the next fiscal year. Renewal periods will always coincide with the state fiscal year. For all enrollees, coverage periods always end June 30, the end of the state fiscal year.
7. Backdating Medical Eligibility	No backdating. The month of application will begin the eligibility period.
8. Eligible Persons	Each person must meet all eligibility requirements. The program will not provide for dependent spouses or widow(er)s under age 65.
9. Application Processing Time	Forty-five (45) days from the date received.
10. Appeals	Medicaid rules will apply.
11.Renewal	To continue SeniorCare benefits without interruption, participants must file a new application prior to the end of their first enrollment period (see item I. 6) and annually thereafter. After the initial enrollment period for each participant, continuous enrollment periods will be 12 months long and will coincide with the state fiscal year. Persons must file Form IL-1363 in a timely manner before their current coverage ends to avoid interruption of coverage. Eligibility will end if a renewal application is not filed and approved. Seniors who lose coverage for failure to file timely can reapply at any time.

12.Resource Eligibility Rules	a. No asset test. b. The income standard will be 200% of the FPL. c. The income of a spouse in the home counts. d. The income standard will be either one person or two person depending on whether there is a spouse in the home. e. Changes in income will be reported only if there are decreases because such changes could benefit the individual in so far as cost sharing is concerned. f. Earned Income Disregards - Not allowed. g. Income counting rules will follow existing policy for Illinois' Pharmaceutical Assistance Program.
13. Spenddown	Not allowed for SeniorCare. However, persons in the spenddown program can also be eligible for SeniorCare. (See Section M describing coordination between programs.)
14.Liens and Estate Claims	Will not apply. Due to the limited nature of the benefit and the cost sharing imposed, Illinois has decided not to make estate claims for benefits received.
15.Third Party Liability (TPL)	TPL rules apply if the person has medical insurance coverage for drugs.

Initial Phase-in: When the program begins all Pharmaceutical Assistance cases (income eligibility level 250% FPL) will be reviewed. Those with income of no more than 200% FPL will be converted by the central data processing system to SeniorCare. A SeniorCare membership card and a notice explaining the additional benefits of SeniorCare will be sent to each person converted.

Annual Redeterminations: After the initial phase-in, persons will reapply annually. A notice and an application will be sent to participants at least three months prior to the end of their enrollment period informing them that they must reapply to continue to receive SeniorCare. After their initial enrollment, subsequent applications can also be made on line.

Intake, Enrollment and Disenrollment: IDR is responsible for the enrollment of persons receiving SeniorCare. All participants will be put on a state fiscal year eligibility period (July 1 through June 30). Therefore, persons enrolled in SeniorCare for the first time between July 1 and December 31 will receive coverage for the remainder of that fiscal year, a period of less than twelve months. Persons enrolled in SeniorCare for the first time between January 1 and June 30 will receive coverage for the remainder of that fiscal year plus all of the next fiscal year.

Nursing Home Residents: Nursing home residents who meet the eligibility requirements may participate in SeniorCare. As a practical matter, the Department expects that virtually all nursing home residents meeting the income requirement of SeniorCare will be meeting their spenddown amount for Medicaid every month and therefore be fully Medicaid enrolled.

Identifying TPL: Persons receiving SeniorCare must sign a statement assigning any prescription drug benefit they may be entitled to receive from a third party resource to the State of Illinois. They also agree to repay any payments they are not entitled to. Persons must also provide proof of any prescription drug coverage they are currently receiving.

Coordination with Medicaid Programs: The Department will not review SeniorCare applications for eligibility for other Medicaid programs. If an individual would like to apply for full Medicaid benefits, they will have to contact the Illinois Department of Human Services to file a separate Medicaid application.

Individuals who are terminated from SeniorCare or fail to re-enroll will not be reviewed for eligibility for other Medicaid programs prior to termination. For further information, see Section M.

J. **Quality**

A discussion of how the State will monitor operations of the program (personnel and systems): The State will monitor the operation and quality of services delivered under this demonstration through a combination of data analysis, utilization review and customer satisfaction.

ESI is the PBM working with IDR to operate the existing pharmaceutical assistance program. IDPA is amending this contract to include expanded coverage to persons at or below 200% FPL. IDPA will monitor operation of the program by consistently analyzing claims data as part of the payment process.

ESI will submit claims data weekly accompanied by a paper invoice. Staff will balance the claims data against the paper invoice and prepare weekly C-13 invoice vouchers payable to ESI for the balanced amount. The claims file will then be matched against IDPA files to obtain recipient numbers and provider numbers. The social security numbers will be matched against IDPA files to identify the recipient identification number of any senior already receiving some kind of assistance. Any seniors not previously receiving assistance will be assigned a recipient number. Any claims that fail to match on recipient number, or fail to create a recipient number for new eligibles will be sent to IDPA's Medical Eligibility Update Unit (MEUU) for resolution. The National Council Prescription Drug Program number (NCPBC) on the claims will be matched to Medicaid provider numbers. Any claims that fail to match on provider numbers will be sent to IDPA's PPU for resolution. As unmatched claims are corrected, they will recycle with the new weekly claims. This continues for 90 days.

"Clean" claims and unmatched claims, which have not been resolved after the 90-day process, will be sent to IDPA's Pharmacy claims processing as encounter claims. This encounter data will be subject to additional edits for valid drug item code, drug appropriate for age, sex, etc. The rejected claims resulting from this process will be reported to the contract manager and ESI. The total amount of rejected claims will be deducted from the next payment to ESI .The "clean claims" and rejected claims resulting from these edits will be sent to MARS (Management Administrative Reporting System). MARS creates files for IDPA's Data Warehouse and SURS (surveillance & utilization reporting system).

SURS will perform the usual exception analysis and will alert the Bureau of Medicaid Integrity to situations warranting further investigation.

The system in place to trigger and alert State to issues that need attention: In addition to data analysis and utilization review, IDPA will rely on information received from the HealthCare Hotline (1-800-226-0768) and the toll free numbers in place at IDOA, IDOI and IDR to monitor the operation of the program and the services received. Calls from seniors will be tracked and problems encountered will be referred to the contract manager for follow up and resolution. The network of community based providers described in the Outreach/Marketing/Training will be trained to report concerns to IDPA to provide a central clearinghouse for all matters pertaining to SeniorCare.

All quality indicators to be employed to monitor products delivered under the demonstration and methodology for measuring such indicators: DUR will be used to assure the appropriateness and quality of services provided under this demonstration. ESI will perform an automated, real-time concurrent DUR screening at the time the pharmacist prepares to fill the prescription. Warning messages will be sent alerting the pharmacist of therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect dosage or duration, drug-allergy interaction and clinical abuse/misuse. As specified in the demonstration application, this is an important check and balance in provision of healthcare to senior citizens that frequently see several physicians to treat medical conditions. The electronic linkage for pharmacies in the ESI network will point these concerns out before the prescription is actually filled and thereby avert more serious and more costly medical problems.

The system in place to ensure that feedback from quality monitoring will be incorporated into the program: Editing as part of concurrent DUR will provide immediate quality feedback to the pharmacist. Retrospective DUR reporting and information obtained through the toll free numbers referenced above will be centrally reported and reviewed by the contract manager.

Quality monitoring surveys to be conducted, and the monitoring and corrective action plans to be triggered by the surveys: IDPA will assess customer satisfaction with the SeniorCare program through periodic surveys of community based providers, enrollees in SeniorCare and possible focus groups as part of the required evaluation of this Research and Demonstration project.

Fraud control provisions and monitoring: Any reports of fraud will be immediately reported to the Office of the Inspector General.

Information that will be collected to coordinate and monitor pharmacy services as they relate to overall health measures: Data will be collected on SeniorCare enrollees over the course of the demonstration to demonstrate that access to needed prescription medications favorably impact overall health measures. Epidemiological data will be used to evaluate health outcomes. Medicare data will be used to assess the age-adjusted rates of death associated with acute and chronic diseases treatable with medications. The health outcomes of Illinois residents with the pharmacy benefit will be compared to low-income seniors in other states and the nation to evaluate the program's effect. IDPA will monitor pre and post demonstration inpatient hospital, nursing home utilization data and other medical services for this population.

K. **Grievances and Appeals**

Normal Medicaid grievance and appeals rights and procedures will apply to SeniorCare participants and all notices of adverse actions will inform participants of appeal rights and procedures.

L. **Evaluation Design**

- **The demonstration hypotheses that will be tested:** IDPA postulates that by providing a comprehensive drug benefit to the senior population up to 200% FPL that many individuals will be able to continue living within the community and not be forced to apply for Medicaid in order to access expensive institutionalized care. This anticipated diversion would result in lower base Medicaid spending than would otherwise have occurred. Thus, overall Medicaid spending for the Medicaid population aged 65+ together with the SeniorCare population will be less than the spending for the Medicaid aged 65+ population would have been during this evaluation period as illustrated in the budget neutrality calculations.

  Outcome measures included to evaluate the impact of the demonstration: Medicaid spending on the 65+ population and the SeniorCare population.

  What data will be utilized: All Medicaid claim data for said populations during the demonstration period.

  The methods of data collection: All data will be extracted from IDPA databases

  How effects of the demo will be isolated: Since the premise is that overall spending will be reduced, IDPA will be using all spending on the affected population. Thus, only the population will need to be isolated. In the event of future Medicaid changes that would affect this population, adjustments will be made to effectively disregard any spending associated with such a change.

M. Interaction with Other Federal and/or State Programs:

Medicare: SeniorCare will fill the current gap in Medicare drug coverage for low-income seniors. Medicare beneficiaries who apply and are found to meet SeniorCare's eligibility criteria will be enrolled in the program. Should the federal government extend drug coverage under Medicare, the state reserves the right to adjust SeniorCare accordingly.

Medicaid:

The following are stipulations regarding coordination between the Medicaid program and SeniorCare:

- IDPA will not review demonstration program applications for eligibility for other Medicaid programs. The Medicaid program has an asset test, which SeniorCare does not have, therefore eligibility for Medicaid cannot be determined from a SeniorCare application. However, SeniorCare applications will be screened for potential Medicaid eligibility based on income and a Medicaid application will be mailed to those seniors. Assistance completing Medicaid applications is readily available to seniors at local Department of Human Services offices. Area Agencies on Aging will be the primary source of face-to-face assistance for SeniorCare application

assistance. Application assistance will also be available through a network of trained senior advocates as described in Section H, as well as through toll free numbers operated by IDPA, Department of Revenue, Department of Human Services, Department on Aging and Department of Insurance.

- Individuals who are terminated from the demonstration program or who fail to re-enroll will not be reviewed for eligibility for other Medicaid programs prior to termination. No one will be terminated from SeniorCare because their income is too low. See below for a discussion of steps Illinois will take to identify SeniorCare participants who may be eligible for Medicaid.

- IDPA will routinely match Medicaid enrollment against SeniorCare enrollment files to identify SeniorCare participants who enroll in Medicaid. IDPA will edit claims for federal financial participation to assure that claims for any dually enrolled individuals will be included only in the regular Title XIX claim. Should an individual's income decrease so that they would be fully Medicaid eligible, that individual would have to submit a complete Medicaid application and be determined eligible through existing procedures if they wanted full Medicaid benefits. There will be no gap in pharmaceutical coverage during the transition from SeniorCare to regular Medicaid.

- IDPA will review SeniorCare enrollment to identify persons whose income appears low enough to qualify for Medicaid as an aged person. That standard is currently 85 percent of poverty and is scheduled to increase to 100 percent of poverty in state fiscal year 2003. Applications for Medicaid will be sent to those individuals inviting them to apply for the full range of Medicaid benefits.

- Persons who qualify for Medicaid only with a spenddown can also be enrolled in SeniorCare. Any SeniorCare cost sharing payments made by such persons may be counted toward their spenddown amounts. As with fully eligible persons, in any period of Medicaid eligibility, IDPA will claim only under the Title XIX Medicaid State Plan, not under the demonstration, for services provided.

- An individual who receives benefits from any of the Medicare Savings programs (QMB, SLIB or QI) may also participate in SeniorCare. Separate applications will be required. SeniorCare enhances the Medicare Savings Programs by providing prescription drug coverage.

Illinois Pharmaceutical Assistance Program: SeniorCare will be closely coordinated with the Illinois Pharmaceutical Assistance Program. A single application will be used for both programs at least during the initial year of the demonstration. Persons will be enrolled in SeniorCare or Pharmaceutical Assistance depending on their incomes. The Pharmaceutical Assistance Program will cover persons with income above 200% of poverty up to a level determined by available funding. In Pharmaceutical Assistance, only a limited set of prescription drugs is available. A single pharmacy benefit management agent will be used for both programs. Although these processes may change during the demonstration period, it is the state's intent that there shall be no overlap or gaps in coverage between SeniorCare and Pharmaceutical Assistance based on the income of participants.

State Programs for Seniors: The Illinois Department on Aging (IDOA) operates a variety of programs for Illinois Seniors. Through the statewide network of Area Agencies on Aging, IDOA will lend considerable support to SeniorCare through outreach and assistance offered to seniors seeking help to enroll. By using this established senior service network, SeniorCare will be promoted across the state at senior citizen centers, congregate meal sites, health fairs and other events targeted at the population likely to be eligible for the program. This will also facilitate close coordination of service delivery by local service agencies.

The Illinois Department of Insurance (IDOI) operates the Senior Health Insurance Program (SHIP) to help inform seniors about benefits for which they may be eligible. IDOI will also collaborate in promoting SeniorCare through SHIP.

Ryan White Care Act Programs

The AIDS Drug Assistance Program (ADAP) under the Ryan White Care Act will remain a payer of last resort. The Department of Public Health cross matches with the IDPA data base for Medicaid eligibility and will also cross match for SeniorCare eligibility. Historically, an extremely small percentage of individuals diagnosed with AIDS have been over 49 years of age. It is expected that there will be very few AIDS patients in SeniorCare.